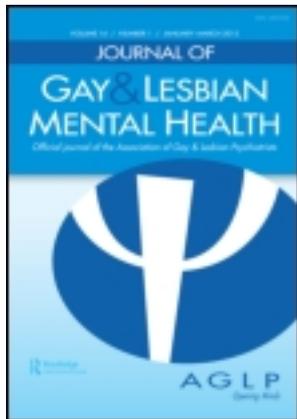


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A Framework for Incorporating Minority Stress Theory into Treatment with Sexual Minority Clients

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REVIEW ARTICLES

A Framework for Incorporating Minority Stress Theory into Treatment with Sexual Minority Clients

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Empirical research has consistently demonstrated the negative mental health consequences of minority stress among lesbian, gay, and bisexual (LGB) populations; however, there is little understanding of how minority stress should be addressed in the actual clinical situation. This article discusses how to incorporate minority stress theory into clinical practice with LGB clients. A proposed framework begins with a two-part clinical assessment. The first part, based on Meyer's (2003) minority stress model, examines the effects of prejudice events, stigma, internalized homophobia, and sexual orientation concealment. The second part, grounded in Hatzenbuehler's (2009) work, examines the client's coping/emotional regulation, social/interpersonal, and cognitive processes, which can be elevated by minority stress. Following the assessment process, the framework suggests using a LGB-affirmative treatment approach. To demonstrate the clinical utility of the framework it will be applied to the treatment of a client identifying as lesbian.

KEYWORDS *lesbian, gay, bisexual (LGB), minority stress, clinical practice, LGB-affirmative psychotherapy, prejudice and discrimination*

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Population-based studies consistently show that lesbian, gay, and bisexual (LGB) individuals have a higher prevalence of mood, anxiety, and substance use disorders than heterosexual individuals (Cochran & Mays, 2000; Cochran, Sullivan, & Mays, 2003; Gilman et al., 2001; Sandfort, de Graaf, Bijl, & Schnabel, 2001). Meyer (2003) hypothesized that higher prevalence of psychiatric disorders among LGB people is a consequence of minority stress. His minority stress theory is based on the notion that, similar to other minority groups, LGB persons face chronic stress due to homophobic and heterosexist social conditions. Meyer's hypothesis was supported by a meta-analysis (see Meyer, 2003) that revealed LGB individuals were about 2.5 times more likely than heterosexual individuals to have a mood, anxiety, or substance abuse disorder at some point in their lifetime and twice as likely to have a current disorder. The higher prevalence of psychiatric disorders among LGB populations is partially explained through the conceptual framework of minority stress (Herek & Garnets, 2007). That is, mental health problems are the result of negative social conditions produced by prejudice and discrimination (Meyer, 2003).

Studies supporting minority stress-based hypotheses have clear implications for programmatic and public policy interventions, particularly those relating to mental health service delivery. Scholars (e.g., Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Haas et al., 2001) have expressed concern about the quality of mental health services that LGB individuals receive. To address this issue, the Gay and Lesbian Medical Association (GLMA) and LGBT Health Experts (2001) recommended community- and hospital-based mental health facilities receiving government funding and reimbursement from Medicaid and Medicare should adopt nondiscrimination policies. In addition, the GLMA and LGBT Health Experts recommended that health insurance companies should maintain provider directories that include up-to-date listings of LGB-affirmative mental health clinicians.

However, the implications for clinical practice with LGB individuals are less clear-cut. Although the extant empirical and clinical literature recommends that mental health practitioners recognize the impact of minority stress (e.g., prejudice events, internalized homophobia, and concealing one's sexual orientation), there is little understanding of how to systematically address it in the actual clinical situation, especially when the implications lend themselves to more programmatic and policy interventions. Increasing our knowledge in this area is necessary for developing effective treatment interventions for LGB individuals seeking psychotherapy to deal with minority stress-related concerns. In fact, a systematic review of the LGB psychotherapy literature revealed the need for specific interventions that help LGB clients cope with the unique challenges related to sexual orientation (King, Semlyen, Killaspy, Nazareth, & Osborn, 2007).

This article provides suggestions on how to incorporate minority stress theory into the clinical treatment with LGB individuals. A proposed

framework begins with a two-part clinical assessment process. The first part, based on Meyer's (2003) minority stress model, examines the effects of prejudice events, stigma, internalized homophobia, and sexual orientation concealment. Based on the work of Hatzenbuehler (2009), the second component examines the client's general psychological processes, including coping/emotional regulation, social/interpersonal, and cognitive processes, which may be elevated by minority stress. These include coping abilities, social support, and maladaptive self-schemas, respectively (Hatzenbuehler, 2009). The inclusion of Hatzenbuehler's work is a necessary component of the framework because it helps clinicians to understand how LGB clients manage the various components of minority stress. Following the assessment process, the framework suggests using an LGB-affirmative treatment approach. In order to demonstrate the use of the framework, I will apply it to the treatment of a black woman who identifies as lesbian.

This framework offers an innovative approach to LGB clinical practice because it: (a) provides a systematic, not general, way to address minority stress in the actual clinical situation; (b) highlights the clinical utility of examining the specific components of minority stress (e.g., stigma and internalized homophobia) as well as the client's general psychological processes, thus offering a comprehensive treatment approach; and (c) demonstrates the use of LGB-affirmative psychotherapy for clients struggling with minority stress, with specific attention to LGB clients of color.

THE MINORITY STRESS MODEL

LGB individuals routinely encounter stressful events not usually experienced by heterosexuals (Herek & Garnets, 2007). Typically involving prejudice and discrimination, these events are the hallmark of minority stress, which is defined as "a state intervening between the sequential antecedent stressors of culturally sanctioned, categorically ascribed inferior status, social prejudice and discrimination, the impact of these environmental forces on psychological well-being, and consequent readjustment or adaptation" (Brooks, 1981, p. 107). (For a detailed discussion of the impact of stressful events on LGB people see Alessi, 2010.)

Because prejudice and discrimination occur unexpectedly, LGB people must constantly readjust to living in a homophobic social environment. Brooks (1981) argued that "'readjustment' becomes, in a sense, adaptation to a perpetual state of stress" (p. 78). When adaptation fails, a pathological stress response such as depression or anxiety may result. Numerous studies have demonstrated the relationship between various forms of sexual orientation discrimination and negative mental health outcomes among LGB populations (e.g., Lewis, Derlega, Griffin, & Krowinski, 2003; Heubener, Rebchook, & Kegeles, 2004; Mays & Cochran, 2001; Warner et al., 2004). Further,

sexual minorities encounter high rates of sexual and physical assault (Heidt, Marx, & Gold, 2005; Tjaden, Thoennes, & Allison, 1999), which is associated with depression, anxiety, and posttraumatic stress disorder (Gold, Dickstein, Marx, & Lexington, 2009; Gold, Marx, & Lexington, 2007; Heidt et al., 2005).

Meyer (2003) developed the minority stress model to understand the relationship between social stress (i.e., prejudice and discrimination) and psychiatric disorders among LGB people. His model was derived from psychological theory, literature on stress and coping, LGB health research, and social and social psychological theories that focus on the effects of stigma and prejudice (Meyer, 2003). He proposed that LGB people encounter minority stress “along a continuum from distal stressors, which are typically defined as objective events and conditions, to proximal personal processes, which are by definition subjective because they rely on individual perceptions and appraisals” (p. 676). Four specific minority stress processes provide the framework for Meyer’s model: (a) chronic and acute prejudice-related events, (b) the expectation of minority stress and the vigilance this expectation requires (stigma), (c) the internalization of negative societal attitudes (internalized homophobia), and (d) concealment of sexual orientation.

The minority stress model also discusses coping and social support. Although it highlights the ameliorating effects of individual coping in determining the effect on mental health (Meyer, 2003), it focuses more on minority group coping. Specifically, minority group members, including LGB people, frequently cope with minority stress by maintaining strong connections to their community. This allows minority group members to evaluate themselves based on others who are similar rather than different. As a result the minority group helps to provide a reappraisal of the stressful condition, which may in turn improve mental health (Meyer, 2003).

MINORITY STRESS AND LGB PEOPLE OF COLOR

Holding more than one minority identity can exacerbate minority stress. Herek and Garnets (2007) proposed that LGB individuals who hold two or more stigmatized identities experience prejudice in majority group contexts (e.g., being black, a woman, and a lesbian) and in minority community settings (e.g., homophobic responses from black heterosexuals and racial prejudice from white lesbians). Meyer, Schwartz, and Frost (2008) found that black and Latino LGB individuals were more likely than white LGB individuals to experience stressful events, including those involving racial/ethnic prejudice, though black and Latino LGB individuals were no more likely than white LGB individuals to experience stressful events involving sexual orientation prejudice.

However, there is evidence that sexual orientation may play a role for LGB individuals of color when it comes to exposure to certain childhood events. Balsam, Lehavot, Beadnell, and Circo (2010) compared experiences of childhood abuse among black, Latino, Asian, and white LGB adults and found that Asian and Latino adults had the highest levels of physical abuse, and black and Latino adults had the highest levels of sexual abuse. Furthermore, associations between childhood abuse and adult mental health outcomes differed with respect to race/ethnicity and type of abuse. For example, posttraumatic stress and anxiety symptoms were associated with emotional abuse among black adults, while these same symptoms were associated with physical abuse among Latino adults.

Few studies have compared prevalence of mental health disorders among white and non-white LGB people. And among these studies, findings were mixed. Meyer, Dietrich, and Schwartz (2008) found that black and Latino LGB participants did not have higher prevalence of mood, anxiety, and substance abuse disorders than white LGB participants. Black LGB participants had fewer psychiatric disorders than both white and Latino LGB participants. However, more black and, especially, Latino LGB participants reported a history of suicide attempts than white participants. Suicide attempts occurred at an earlier age for black and Latino participants, which may suggest that they coincided with a coming-out period. Using the same sample, Alessi, Meyer, and Martin (2013) found that black and Latino LGB individuals did not have higher prevalence of posttraumatic stress disorder (PTSD) than white LGB individuals; however, when the authors relaxed diagnostic criteria for PTSD by allowing stressful events that did not pose threat to life or physical integrity to qualify toward a PTSD diagnosis, Latino LGB individuals had higher prevalence of PTSD than both white and Black LGB individuals. While findings from these two studies are inconsistent with minority stress theory, Alessi et al. (2013) suggested that they are not surprising; studies that compared prevalence of mental disorders among diverse samples of the U.S. population showed similar findings. Despite the nature of these contradictory findings, clinicians should be aware that LGB people of color face the “cultural complexities” of holding two minority statuses (Smith, 1997, p. 282). The additive effects of racial and sexual orientation prejudice may cause higher levels of stress, which in turn may affect psychosocial functioning.

GENERAL PSYCHOLOGICAL PROCESSES

The minority stress model is used to partially explain the connection between group-specific processes and negative mental health outcomes among LGB people. Group-specific processes refer to both distal (objective prejudice events) and proximal (stigma, internalized homophobia, and concealment

of sexual orientation) stressors (Meyer, 2003). Generally, identifying as a sexual minority person leads to higher levels of stress, which in turn confers increased risk for psychopathology.

However, comprehensive approaches to clinical practice with LGB clients (and heterosexual clients, for that matter) require an understanding of more than group-specific processes. It is also important to understand the role of general psychological processes when conducting clinical interventions with LGB individuals (Hatzenbuehler, 2009). General psychological processes refer to the client's coping/emotional regulation, social/interpersonal, and cognitive processes, which may be elevated by minority stress (Hatzenbuehler, 2009). As discussed earlier, these include coping abilities, social support, and maladaptive self-schemas respectively.

According to Hatzenbuehler (2009), LGB individuals encounter excess levels of stress due to their marginalized status; this stress in turn creates elevations in general psychological processes that confer risk for psychopathology. Hatzenbuehler proposed a psychological mediation model in which the relationship between minority stress (i.e., distal stressors) and psychopathology is mediated by general psychological processes. His psychological mediation model builds on Meyer's (2003) minority stress model as well as studies demonstrating elevated general psychological process among LGB populations compared to heterosexual populations.

Researchers are beginning to examine the role of potential mediators in the relationship between minority stress and mental health outcomes among LGB people, though studies have yet to examine the role of general psychological processes specifically. For example, Wight, LeBlanc, de Vries, and Detel (2012) found that sense of personal mastery partially mediated the relationship between gay-related stressors (as well as aging-related stressors) and depressive symptoms among older adult gay men. Another study (Lehavot & Simoni, 2011) showed that social support and spirituality mediated associations between minority stressors (i.e., sexual orientation victimization, internalized homophobia, and concealment) and mental health among lesbians, though there were direct links between victimization and substance abuse and internalized homophobia and substance abuse. Feinstein, Goldfried, and Davila (2012) found that internalized homophobia and rejection sensitivity mediated the relationship between discrimination experiences and symptoms of depression and social anxiety among LGB participants, suggesting that perceptions and appraisals play a role in determining mental health outcomes following such experiences.

A discussion of Hatzenbuehler's (2009) psychological mediation model and Meyer's (2003) minority stress model offers the foundation for a comprehensive approach to clinical practice by identifying how group-specific factors *and* the elevation of general psychological processes contribute to mental health problems among LGB people. An LGB person's general psychological processes are likely to reflect the way in which s/he manages

prejudice, stigma, internalized homophobia, and concealment/disclosure. Along the same line, Hatzenbuehler asserts that “exclusive focus on either process alone—without consideration of their interrelationships—may hinder the development of effective theory on the determinants of mental health disparities among sexual minorities, as well as prevention and intervention efforts with this population” (p. 707).

APPLICATION OF THE MINORITY STRESS FRAMEWORK

The following sections will present the application of the minority stress framework for clinical practice with LGB clients. The case example will highlight the complexities that may emerge when working with clients struggling with minority stress and also discuss the challenges faced by LGB clients of color, particularly those identifying as black.

The Case of Brittany

Brittany,¹ a verbal and intelligent 25-year-old black female employed as an account manager for a large corporation, identified stress, anxiety, and sexual orientation confusion as the primary reason for seeking treatment. She presents as androgynous—she does not wear make-up, has short hair, and frequently wears dark-colored clothing. Brittany identifies as lesbian but struggles with accepting her sexual orientation. She has disclosed her sexual orientation to very few people and has little connection to the LGB community. She would like to meet other LGB people, but experiences high levels of anxiety in social situations.

Brittany has always felt different from others. She was teased in grade and middle school, and family members frequently compared Brittany with her older cousin who was more “feminine.” While growing up, Brittany spent most of her time with one or two close friends. She went away to college, and although she made some friends, she spent much of her time alone. She never had a romantic relationship, and attributes this to sexual orientation confusion and high levels of anxiety. In social situations, she fears that she will be perceived as boring, have nothing to contribute, and be judged for saying the “wrong thing.” Brittany has trouble recognizing her strengths, which include a good sense of humor, a great appreciation of art and literature, and an interest in social activism.

She does not socialize much on the weekends and spends most of her time at home. When she does socialize, it is usually with friends from work. She maintains friendships with some of her co-workers, but they do not know she identifies as lesbian. When her co-workers discuss relationships and dating, Brittany remains silent. She does not want to come out because she worries about being the subject of “office gossip.” While she does not

feel her work environment is overtly hostile to sexual minorities, she has overheard and also been part of conversations in which co-workers made disparaging remarks about LGB people. Diagnostic assessment revealed that Brittany met criteria for social phobia and dysthymic disorder according to the *Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*; American Psychiatric Association, 2000).

Minority Stress Assessment

As discussed previously, the minority stress assessment is a two-part process. The first part examines the four minority stress components: exposure to prejudice events, stigma, internalized homophobia, and sexual orientation concealment. The second part examines the client's coping/emotional regulation, social/interpersonal, and cognitive processes. The following subsections provide a detailed assessment in order to demonstrate how minority stress impacted Brittany's psychosocial functioning.

Exposure to Prejudice Events

Stressful events involving prejudice can be acute or chronic. Acute stressful events cause a significant change in a person's life, while chronic stressful events consist of everyday discrimination (e.g., being treated with less respect or receiving poor services) and stigma (which will be discussed in detail below) (Meyer, Schwartz, & Frost, 2008). Although Brittany had not encountered any recent acute prejudice events, she was bullied during her early adolescent years and chastised by family members for exhibiting gender-incongruent behavior. As a result, Brittany spent most of her time alone, and she continues to use isolation as a way to cope with minority stress as an adult. To fully understand the developmental processes of LGB individuals, clinicians should be aware of the effects of sexual orientation discrimination on their clients' childhood and adolescent experiences (D'Augelli, 2006) as well as the compounding effects of prejudice based on other minority identities.

Stigma

Stigmatized individuals are faced with the dilemma of continually having to discern what others are thinking about them, and they are likely to interpret their daily interactions as being undermined by the dominant group (Goffman, 1963). Brittany believes that others will judge her and think less of her for being a lesbian, and this is exacerbated by the stigma she experiences as a black woman. She enters most social situations with the belief that she will be rejected and, as a result, appears detached, quiet, or aloof. It is not uncommon for stigmatized individuals to maintain a high degree of vigilance

in their interactions with the dominant group. This is not necessarily pathological. In fact, this vigilance can be protective; it may help LGB people cope with negative appraisals and also motivates them to seek out positive social supports (Kaufman & Johnson, 2004). For Brittany, it is problematic because she overestimates threat in situations that are LGB-affirming. In addition, she finds it hard to meet people at social events intended for lesbians of color.

Internalized Homophobia

Brittany presents the common manifestations of internalized homophobia, which is “the gay person’s direction of negative social attitudes toward the self” (Meyer & Dean, 1998, p. 161). For instance, she avoids contact with other LGB people, is uncomfortable with same-sex sexual desire, and often feels alienated from herself. While some of Brittany’s defense mechanisms protect her from distress associated with identifying as lesbian (e.g., disclosing her sexual orientation, meeting other LGB people, and engaging in same-sex behavior), Davies (1996b) proposes that these defense mechanisms also make her feel disconnected from others. Because of early developmental experiences and continued exposure to a heterosexist society, internalized homophobia remains an important issue even after coming out as lesbian, gay, or bisexual (Meyer, 2003). This may be even more important to consider for Black LGB individuals, such as Brittany. In a study (Szymanski & Gupta, 2009) examining the additive effects of internalized homophobia and internalized racism among lesbian, gay, bisexual, and questioning black adults, both variables were unique predictors of self-esteem. However, when internalized homophobia and internalized racism were examined in relation to psychological distress, only internalized homophobia predicted psychological distress. The authors suggested that this might be due to the participants’ belief that the black community is intolerant of homosexuality.

Sexual Orientation Concealment

Brittany’s connection to the black community is tied to her relationship with her immediate family and therefore affects her decision-making process about sexual orientation disclosure. Brittany came out to one family member (her older cousin), who responded positively to the news. More recently Brittany told her father that she went to a lesbian club. Her father did not acknowledge this comment, which made Brittany feel she should not discuss it anymore. She believes that coming out could threaten her relationship with her father, even though she suspects he may already know that she identifies as lesbian.

Brittany has not come out to co-workers either. When they converse about dating and relationships, she remains silent because she worries about being the subject of “office gossip” and does not want to make a “big deal

about being a lesbian.” While concealing one’s sexual orientation may offer protection from a hostile social environment, those who conceal must also contend with the on-going threat of discovery. Pachankis (2007) proposed that this threat leads to four specific psychological responses: vigilance, suspiciousness, and preoccupation (cognitive); shame, guilt, anxiety, and depression (affective); social avoidance, the need for feedback, and impaired relationships (behavioral); and identity ambivalence, negative view of self, and diminished self-efficacy (self-evaluation). Brittany manifests these psychological responses on a daily basis. She feels concealing her sexual orientation prevents her from having authentic relationships with people, which in turn increases her feelings of disconnection from others. At the same time, it is likely that past experiences of being judged or feeling different have been integrated into Brittany’s defensive system, making hiding feel necessary for self-protection (Drescher, 1998).

Assessment of General Psychological Processes

COPING/EMOTIONAL REGULATION

Brittany frequently uses avoidance as a way to contend with stigma, internalized homophobia, and concealment. For example, she isolates herself and spends most of her free time surfing the Internet, which she finds easier than online dating or joining a lesbian social group. She also engages in rumination, which is a risk factor for depression and anxiety (Hatzenbeuhler, 2009). For example, she will spend hours thinking about whether she should date or come out to co-workers.

SOCIAL/INTERPERSONAL

She has few social supports and little connection to the LGB community, which makes it difficult for her to manage stigma and internalized homophobia. She would like to meet other LGB people, but she experiences difficulty in social situations and high levels of rejection sensitivity. Although isolating herself during childhood and adolescence was an adaptive response for dealing with a hostile social environment, it is now associated with depression. Identifying as black may also limit her ability to meet other lesbians who can relate to the complexities of holding more than one minority status (Greene, 2000).

COGNITIVE

Brittany had a number of negative self-schemas associated with the core belief that she is unlovable (Beck, 2011). Stigma, internalized homophobia, and the need to conceal her sexual orientation strengthen these negative self-schemas. She believes that she does not have much to offer people and sees herself as “boring,” even when she is around other LGB people. She

expresses feelings of hopelessness and does not believe that she will be able to fully accept her lesbian identity.

LGB-Affirmative Treatment

The therapeutic approach used with Brittany was integrative, incorporating techniques from cognitive behavioral therapy and psychodynamic psychotherapy. Cognitive behavioral interventions were used to challenge automatic thoughts, modify core beliefs, increase coping skills, and to offer encouragement and support, while psychodynamic techniques were used to maintain a nonjudgmental stance, evoke negative affective states, and to process the patient-therapist relationship (Jones & Pulos, 1993). Integrating these approaches provides clinicians with the tools to deal with the complex problems frequently encountered in community mental health and private practice settings.

Engaging Brittany in the therapeutic process was difficult. She had trouble with self-disclosure and was skeptical about whether treatment would work. Having a gay-identified therapist eased some of Brittany's concerns during the initial stages of treatment; however, the use of LGB-affirmative psychotherapy techniques can help to foster collaboration, regardless of the therapist's sexual orientation (Davies, 1996a). King et al.'s (2007) systematic review of the LGB counseling literature revealed that therapists' sexual orientation was less important to LGB clients than the therapist's attitude, knowledge, and practice skills. On the other hand, therapists should not assume that questions about their sexual orientation relate to resistance or transference issues on the part of the client. LGB clients may inquire about the therapist's sexual orientation as a way of discerning whether it is safe to discuss LGB-related issues. Therapists should evaluate their client's need to know their sexual orientation and be prepared to disclose it when necessary (Drescher, 1998).

LGB-affirmative psychotherapy is not an independent practice approach. Its purpose is to enhance the therapist's existing treatment model (e.g., cognitive behavioral, psychodynamic, or humanistic) (Davies, 1996a). However, LGB-affirmative psychotherapy differs from traditional treatment modalities. The LGB-affirmative practitioner "celebrates and advocates the validity of lesbian, gay, and bisexual persons and their relationships" (Tozer & McClanahan, 1999, p. 736). According to King et al. (2007), clients' experiences of LGB-affirmative therapy usually involve "therapy in which homosexuality and bisexuality are regarded positively, prejudice is avoided, the stress of externalised and internalised anti-homosexual bias is recognized, and there is sensitivity to [LGB] development, culture and lifestyles" (p. 32). Mental health practitioners should not underestimate the importance of using LGB-affirmative approaches; practicing without discriminating is not the same as practicing affirmatively (Crisp, 2006).

Helping clients cope with stigma is an important LGB-affirmative psychotherapy technique. For example, I normalized Brittany's anger about working with colleagues who made inappropriate comments about homosexuality. I informed her that the workplace should be free of discrimination and harassment, and that there were options for dealing with this situation if she chose to, such as reporting it to her supervisor or informing her colleagues that these remarks made her uncomfortable. Using the therapist's authority to counter harsh criticism against LGB people deprograms stereotypes about homosexuality (Davies, 1996a). Indeed, there is concern that treatment with LGB clients is overly focused on intrapsychic processes, and thus fails to acknowledge how macro-level forces shape their feelings, attitudes, and behaviors (Glassgold, 2007; Russell & Bohan, 2006).

In addition, Brittany contends with stigma related to her black identity. Focusing on the challenges related to these intersecting identities (i.e., being black and lesbian) was integral to helping Brittany deal with her depressive symptoms. It was important for me, particularly as a white therapist, to convey that I appreciated the struggles she experienced not only as a lesbian but also as a black lesbian. Greene (2000) asserts that black lesbians encounter the complex task of integrating more than one identity in a society that devalues them at all levels. This process is further complicated, Greene adds, by the homophobic assumption made by some that identifying as lesbian is contradictory with a genuine "black" identity. Because the racial identity of black individuals usually develops before they are aware of their same-sex feelings, the ability to cope with homophobia may be delayed (Greene, 2000).

I acknowledged the challenges of living with both sexual orientation- and race-related stigma, which helped Brittany to see that she internalized negative attitudes toward homosexuality. However, before we could explore this further, we had to build a strong therapeutic relationship. This was particularly important because Brittany exhibits an anxious attachment style. Sherry (2007) found associations between fearful and preoccupied attachment styles and internalized homophobia, shame, and guilt, and thus suggests helping clients deal with internalized homophobia by strengthening the therapeutic relationship. I strengthened the therapeutic relationship by periodically checking-in to see whether Brittany felt validated, accepted, and understood. A willingness to hear the client's concerns and complaints helps to facilitate the therapeutic holding environment (Drescher, 1998), which is essential for treatment.

Attachment-based approaches may be especially helpful for LGB clients with intimacy problems, because the therapist functions as "a conduit through which new, secure, [cognitive working models] of attachment can be created between therapist and client" (Sherry, 2007, p. 223). The facilitation of these new cognitive working models may decrease shame and guilt and enable the client to connect with others in new ways. It may be helpful

to create these new cognitive working models before suggesting that clients, for example, attend LGB social events, because they may not be ready to develop close relationships with others (Sherry, 2007). Using exposure techniques before these new working models are in place may increase feelings of failure and thus precipitate more anxiety in future exposure exercises.

High levels of internalized homophobia may have an impact on sexual orientation disclosure. Weber-Gilmore, Rose, and Rubinstein (2011) found associations between internalized homophobia and whether LGB people were out to friends, co-workers, and extended family. Surprisingly, however, internalized homophobia did not predict whether LGB people were out to nuclear family members. This finding suggests that the relationship between internalized homophobia and coming out may be complex. Some LGB people may decide not to reveal their sexual orientation in certain situations, even if they completely accept their LGB identity, indicating that outness may be influenced by situational and environmental circumstances rather than internal conflict (Frost & Meyer, 2009).

Holding two minority statuses complicated Brittany's concerns about self-disclosure. Deep family connections may exacerbate sexual orientation conflict when one's cultural community (e.g., religious institutions, extended family) does not accept homosexuality (Smith, 1997). To maintain connections to the larger cultural community, some LGB individuals of color, such as Brittany, remain closeted to family members (Greene, 1994). Coming out to family members present numerous challenges, since there is a possibility of losing one's racial/ethnic support system as a result of identifying as LGB (Szymanski & Gupta, 2009). Early sexual identity development models (Cass, 1979, 1984; Troiden, 1979) conceptualized homosexual identity development as a stage process in which individuals progress from feeling different to acceptance of their homosexual identity (Loiacano, 1989). However, these models may not account for cultural variations among non-white LGB individuals who may place less emphasis on coming out than white individuals (Loiacano, 1989). Furthermore, some individuals, regardless of their race/ethnicity, may not identify with the stages in these sexual identity development models at all.

Thus, I proceeded cautiously when we discussed issues of disclosure. Brittany's hesitation about coming out to her parents was understandable, given her father's silence after disclosing that she (Brittany) went to a lesbian club. Practitioners should not minimize ethnic/racial minority clients' concerns about coming out to members of their ethnic community (Liddle, 2007). It will be important to monitor one's countertransference when addressing disclosure issues, since there is the risk of pushing clients to come out before they are ready (Alessi, 2008). This can result in unintended consequences, which some clients may be unequipped to deal with. Because of intense pressure to please the therapist, some clients may also terminate treatment (Alessi, 2008). Exploring Brittany's concern about coming out to

her family members allowed us “to make room for her definition of family within her family of origin. It is this conflict, and not sexual object choice, that impedes her ability to sustain healthy and satisfying levels of intimacy” (Jacobo, 2001, p. 681). Focusing on this conflict helped Brittany to cope with some of her concerns about coming out.

Improving Brittany’s coping processes was a primary focus of treatment. While avoidance may be adaptive in the short term, it inadvertently reinforced Brittany’s notion that she could not cope effectively. Because Brittany used avoidance to cope with anxiety-provoking situations, I used cognitive behavioral techniques to help reduce and manage her anxiety. For example, we scheduled a “worry-time” to help decrease rumination (Freeman, Pretzer, Fleming, & Simon, 2004). In addition, she started to monitor her Internet usage and also began to leave the house for a few hours, even if she did not have plans.

As Brittany’s ability to cope with anxiety improved, we focused on increasing her social supports. I worked with Brittany to identify social groups that she found interesting. In order to do this, therapists should be aware of resources in the LGB community (Saari, 2001). Brittany attended a number of events for lesbians of color and also tried on-line dating. However, there were times when Brittany was hard on herself when she did not enjoy a social event or did not connect with someone on a first date. We spent a significant amount of time processing her sadness, disappointment, and frustration. Despite her concerns, connecting with members of the LGB community remained important to her, and she was amenable to using exposure techniques to cope with social phobia. (For an in-depth discussion of using cognitive behavioral techniques to treat LGB clients with social phobia, see Safran and Rogers, 2001.)

In addition, analyzing the transference provided Brittany with information about how she interacts with others. For example, during sessions she would suddenly stop talking because she “doesn’t know what to say.” At times, she responded to innocuous comments with a sarcastic and irritable tone. She also felt the need to please me, which inhibited her from responding spontaneously. As discussed previously, Brittany’s fears of rejection stemmed from negative self-schemas associated with the core belief that she is unlovable. She struggled with feelings of hopelessness and at times felt she had too many barriers to overcome. During this period, it was important to identify automatic thoughts and challenge cognitive distortions that exacerbated depressive symptomatology.

Although Brittany is much more comfortable with her sexual identity, she continues to struggle with minority stress. The dynamic interplay between minority stress and the LGB client’s general psychological processes can maintain negative outcomes (Hatzenbuehler, 2009). For example, Brittany’s difficulty coping with stigma exacerbates it, which then makes it harder for her to cope. Or her lack of connection to the LGB community intensifies

her need to conceal her sexual orientation, which then makes it harder for her to meet LGB people. It was not uncommon for Brittany to express frustration. After normalizing her feelings of frustration, I worked with her to realistically appraise her progress. She made notable improvements. She participated in lesbian social groups, tried on-line dating, came out to one of her co-workers, and was more comfortable with her sexual orientation. However, she had trouble sustaining some of her progress. She continued to struggle with depressive episodes and had trouble practicing the social skills she learned in treatment. Brittany would require long-term treatment to help her cope with minority stress as well as social anxiety and depression.

LIMITATIONS AND FUTURE RESEARCH

Brittany's case provided an example of how to apply the minority stress framework to clinical practice with LGB individuals. She struggled with stigma, internalized homophobia, and concerns related to sexual orientation concealment. Her coping/emotional regulation, social/interpersonal, and cognitive processes were impaired by stigma-related experiences, making it difficult for her to manage minority stress. Although Brittany's social anxiety and depression decreased and her social functioning improved for a period of time, without the use of objective measures (e.g., symptom scales) it is difficult to know the actual effect of treatment and whether assessing Brittany through the lens of the minority stress framework enhanced treatment in any way.

Practitioners should keep in mind that all cases will not be as clear-cut as Brittany's. LGB clients enter mental health treatment to deal with a number of problems, not just sexual orientation-related issues (King et al., 2007), which can make it difficult to fully understand the impact of minority stress on the client's psychosocial functioning. The differential impact of each minority stress component (e.g., stigma, internalized homophobia) is not always evident and does not affect all clients equally (P. Goldblum, personal communication, September 5, 2012). Thus, there is a possibility that clinicians might under- or overestimate the impact of minority stress. As Newcomb and Mustanski (2010) stated: it is preferable to assess the impact of minority stress "... with each client rather than making assumptions about the detrimental effects of these variables" (p. 1028). In a similar vein, while sexual minority individuals share common minority stressors, the identities and experiences of lesbian and bisexual women should be differentiated from the identities and experiences of gay and bisexual men (Fassinger & Arseneau, 2007).

Further research is needed to develop an assessment tool that can reliably assess minority stress among LGB clients seeking mental health treatment. This assessment tool should also be able to capture the effects

of living with more than one minority identity. In the meantime, applying the minority stress framework to clinical practice provides a starting point for understanding the impact of a hostile social environment on the psychosocial functioning of LGB people.

NOTE

1. Identifying information was changed to protect the client's privacy.

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